LFC Requester:	Eric Chenier

AGENCY BILL ANALYSIS - 2026 REGULAR SESSION

WITHIN 24 HOURS OF BILL POSTING, UPLOAD ANALYSIS TO
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(Analysis must be uploaded as a PDF)

SECTION I: GENERAL INFORMATION

{Indicate if analysis is on an original bill, amendment, substitute or a correction of a previous bill}

Date Prepared: 2/5/26 **Bill Number:** SB0220 **Original** X **Amendment** **Substitute**
Short Title: MINIMUM MEDICAID REIMBURSEMENTS FOR PERSONAL CARE SERVICES
Sponsor: Sen. Pinto, Rep. Dow
Name and Code Number: HCA 630
Person Writing: Carlos Ulibarri, Kristen Borders Wood
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SECTION II: FISCAL IMPACT

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Nonrecurring	Fund Affected
FY26	**FY27**		
0	$51.400.0	Recurring	General Fund

(Parenthesis ( ) indicate expenditure decreases)

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY26	**FY27**	**FY28**		
0	**$51,400.0**	**$51,400.00**	Recurring	General Fund

(Parenthesis ( ) indicate revenue decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

FY26	FY27	FY28	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
$0.0	$24,448.1	$24,448.1	$48,896.2	Recurring	Medicaid Program General Fund
$0.0	$61,273.0	$61,273.1	$122,546.0	Recurring	Medicaid Program Federal Fund
$0.0	**$85,721,1**	**$85,721.1**	**$171,442.2**	Recurring	**Medicaid Program Total**
$0.0	$40.0	$40.0	$80.0	Recurring	Medicaid Admin General Fund
$0.0	$40.0	$40.0	$80.0	Recurring	Medicaid Admin Federal Fund
$0.0	**$80.0**	**$80.0**	**$160.0**	Recurring	**Medicaid Admin Total**
$0.0	**$85,801.1**	**$85,801.1**	**$171,602.2**	Recurring	**Medicaid Grand Total**

(Parenthesis ( ) Indicate Expenditure Decreases)

~~FY26~~	~~FY27~~	~~FY28~~	~~3 Year Total Cost~~	~~Recurring or Nonrecurring~~	~~Fund Affected~~	
~~$0.0~~	~~$0.0~~	~~$51,360.0~~	~~$51,360.0~~	~~$102,720.0~~	~~Recurring~~	~~Medicaid Program General Fund~~
~~$0.0~~	~~$0.0~~	~~$128,721.2~~	~~$128,721.2~~	~~$257,442.5~~	~~Recurring~~	~~Medicaid Program Federal Fund~~
~~$0.0~~	~~**$0.0**~~	~~**$180,081.2**~~	~~**$180,081.2**~~	~~**$360,162.5**~~	~~**Recurring**~~	~~**Medicaid Program Total**~~
~~$0.0~~	~~$0.0~~	~~$40.0~~	~~$40.0~~	~~$80.0~~	~~Recurring~~	~~Medicaid Admin General Fund~~
~~$0.0~~	~~$0.0~~	~~$40.0~~	~~$40.0~~	~~$80.0~~	~~Recurring~~	~~Medicaid Admin Federal Fund~~

~~$0.0~~	**~~$0.0~~**	**~~$80.0~~**	**~~$80.0~~**	**~~$160.0~~**	**~~Recurring~~**	**~~Medicaid Admin Total~~**
~~$0.0~~	**~~$0.0~~**	**~~$180,161.2~~**	**~~$180,161.2~~**	**~~$360,322.5~~**	**~~Recurring~~**	**~~Medicaid Grand Total~~**

(Parenthesis ( ) Indicate Expenditure Decreases)

SECTION III: NARRATIVE

BILL SUMMARY

Synopsis: SB0220 makes an appropriation of $51.4 million from the General Fund to the Health Care Authority (HCA) for expenditures in FY27 and amends the Public Assistance Act, Ch. 27, art. 1 NMSA 1978, to create the Medicaid personal care services fee schedule and increase Medicaid reimbursement for personal care services pursuant to Section 1 of the bill. SB0220 would also require that direct care workers be reimbursed for at least 70% of the payment to the agency. Any unexpended balance remaining at the end of fiscal year 2027 would revert to the general fund.

This bill duplicates HB83 FY26 and SB0140 FY26. The bill's fiscal impacts relate to HB55 FY25.

FISCAL IMPLICATIONS

The fiscal impact analysis relates to the adjustment of Medicaid fee schedules reflecting minimum wage reimbursement to rendering Personal Care Service providers. The fiscal impact analysis also recognizes HCA's need to hire an additional FTE to monitor/administer record-reporting and documentation of PCS reimbursement across Agency-Based providers.

SB220, as amended, requires HCA to implement minimum reimbursement rates for PCS of (1) $23.50/hour for consumer-delegated PCS and (2) $19.78/hour for consumer-directed PCS. Both reimbursement rates exclude GRT. Consequently, GRT is deducted before calculating the minimum Medicaid reimbursements that PCS agencies receive. (Note HCA has published a recommended payment rate of $20.40 per hour for Consumer Delegated PCS and $17.20 for Consumer-Directed PCS, via Letter of Direction LOD #59. Consequently, relative to LOD #59, SB220 would increase the minimum payments by $3.10 per hour for Consumer-Delegated PCS and $2.58 per hour for Consumer-Directed PCS, approximately a 15.2% increase.)

HCA understands SB 220 will benefit Medicaid PCS/ADL providers and members from higher reimbursement rates, effectively supporting the size and quality of the PCS workforce and access to care for members. In CY 2025, Managed Care Organizations reported spending $564.1 million on services directly related to the bill. These included: $333.8 million for Activities of Daily Living (ADL, CPT 99509), across 125 provider agencies servicing 17,542 distinct clients; $214.6

million for PCS (HCPCS T1019), and $15.7 million for Assisted Living Waiver Per Diems (HCPCS T2031). Applying a 15.2% increase to these costs would impact the Medicaid program by $85,721.1 thousand in FY 2028 and recurring years.

~~HCA has published a recommended payment rate via Letter of Direction #59. This bill would provide an increased minimum payment for Consumer Delegated members at $23.50 per hour, an increase of $3.10 per hour compared to LOD #59. LOD #59 recommends a reimbursement of $20.40 per hour. The bill also provides an increased minimum payment for Consumer Directed members at $19.78 per hour, an increase of $2.58 per hour compared to LOD #59. LOD #59 recommends a reimbursement of $17.20 per hour.~~

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~~In CY 2025, Managed Care Organizations reported spending $563.1 million for services directly related to the bill. These included: $333.8 million for Activities of Daily Living (ADL, CPT 99509), across 125 provider agencies servicing 17,542 distinct clients; $214.6 million for PCS (HCPCS T1019), and $15.7 million for Assisted Living Waiver Per Diems (HCPCS T2031). HCA understands the Act will benefit Medicaid PCS/ADL providers and members from higher reimbursement rates, effectively bolstering the size and quality of the underlying workforce and access to care for a significant number of members.~~

SIGNIFICANT ISSUES

The proposed legislation would potentially benefit 28,024 current service recipients in the Community Benefit Program in CY 2025, and 195 Billing Provider Agencies. Personal Care Services are not currently captured by Fee Schedules in the Medicaid Program. Consequently, Managed Care Organizations (MCO) have discretion in reimbursing PCS. The bill would implement Fee schedules for Agency-Based PCS. However, the bill (as currently drafted) excludes the Self-Directed Community Benefit model as well as the 1915-C Waivers. Consequently, the bill would create disparity between reimbursements of similar services rendered throughout Medicaid programs.

The bill requires HCA to establish a minimum fee schedule for reimbursing Personal Care Services. The fee schedule must be established between HCA and CMS. This process is estimated to take between six (6) and twelve (12) months.

The oversight required to ensure that 70% of MCO payments go directly to direct care workers would be a new function of the Medicaid agency. It would require PCS agencies to report their overhead costs, travel, training, and personal protective equipment costs and the hourly wage rates they pay. That data would then need to be compared to the MCO reports since MCOs are permitted to negotiate rates. This level of oversight and reporting would require one (1) new Full Time Employee (FTE).

In spring of 2024, the federal Centers for Medicare and Medicaid Services (CMS) issued the *Ensuring Access to Medicaid Services* final rule, also known as the Access Rule. The Access Rule

establishes a payment adequacy minimum performance standard requiring states to ensure that 80% of Medicaid payments go to direct care worker compensation by July 9, 2030. CMS has yet to publish guidance on the payment adequacy minimum performance standard and how states will be required to implement, monitor and enforce it. CMS has not published clear information as to whether this rule will be enforced in the current administration.

PERFORMANCE IMPLICATIONS
Also, PCS provider agencies would be required to use at least 70% of Medicaid reimbursements to cover direct care workforce expenditures. PCS provider agencies must maintain documentation that 70% (or higher) of Medicaid reimbursement is spent on direct care workforce expenditures and make those records available to HCA within a reasonable amount of time.

ADMINISTRATIVE IMPLICATIONS
The administrative impact on HCA would be in securing federal approval for the general fund for PCS provider wages and direct care worker compensation, identifying affected providers and waiver service categories, and overseeing/monitoring the implementation. This would require a Medicaid Supplement to providers, a Medicaid Letter of Direction to the MCOs, and MCO Policy Manual update.

The oversight required to ensure that 70% of MCO payments go directly to direct care workers would be a new function of the Medicaid agency. It would require PCS agencies to report their overhead costs, travel, training, and personal protective equipment costs and the hourly wage rates they pay. That data would then need to be compared to the MCO reports as at this time MCOs are permitted to negotiate rates. This level of oversight and reporting would require one (1) new Full Time Employee (FTE).

ITD will need to assist with any necessary system modifications required to implement the bill's mandates, specifically the new requirements around PCS agencies. The ITD ODA team will also need to be involved in any of these changes that impact reporting requirements.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP
SB0220 is a duplicate bill of SB0140 FY26 and HB83 FY26 and also relates to HB55 FY25.

TECHNICAL ISSUES
There are no known technical issues at this time.

OTHER SUBSTANTIVE ISSUES
None at this time.

ALTERNATIVES
None at this time.

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL
If SB220 is not enacted, there will not be any change to the current reimbursement to PCS providers and direct care staff. At this time, there is not a minimum fee schedule for Agency-Based Community Benefit services. Rates will continue to be paid at the discretion of the MCOs with

guidance from Letter of Direction #59.

AMENDMENTS
none